Application for Drug Medi-Cal Program Participation for Substance Abuse Clinics

General Instructions

This application is to be used to apply for Medi-Cal program participation as a substance abuse clinic as well as to submit information regarding changes in clinic information. For instructions on which portions of the application to complete for different types of certification activities, please refer to the next page, entitled *Specific Instructions.*

Substance abuse clinics are certified for Medi-Cal program participation by the Department of Alcohol and Drug Programs (ADP). To apply for certification, complete pages 1-4 of the attached application (form ADP 8001) and submit the completed application to:

Department of Alcohol and Drug Programs
Residential and Outpatient Programs Compliance Branch
1700 K Street
Sacramento, CA 95814-4037

The Medi-Cal certification requirements for substance abuse clinics are contained in the Drug Medi-Cal Certification Standards for Substance Abuse Clinics; the Standards for Drug Treatment Programs; and Title 22, California Code of Regulations Sections 51341.1, 51490.1, and 51516.1. Reading each of these documents before completing an application is important.

In addition to completing the attached application and supplying the ADP with the required supportive documentation, applicants must also complete and submit the Medi-Cal Disclosure Statement (form DHS 6207) included in the application package.

A copy of the referenced portions of Title 22 can be obtained from the Department of Alcohol and Drug Programs by calling (916) 322-2911.

Specific Instructions

Listed below are specific instructions for completing the application for different types of Drug Medi-Cal (DMC) certification activities. All applicable portions of the application must be fully and accurately completed with current information. Supportive documents must accompany the application. Retain a copy for your records. **For all types of applications, the signature of an authorized official, including a copy of the individual's authorization to sign, is required.**

Original Application

A substance abuse clinic or satellite site applying for initial DMC certification must complete all sections of the four-page application and supply all required documentation. If a section is not applicable, please enter the notation N/A in the space provided. In addition, a Medi-Cal Disclosure Statement (DHS form 6207) must accompany the application.

Additional Services or Funding

A substance abuse clinic or satellite site applying for additional services or funding must complete Items I, V, VI, VII, VIII (for each additional service), IX (if applicable), XII, XIV, and any other Items necessary to report a change in information.

Adding Satellite Site

A substance abuse clinic adding a satellite site clinic (which is defined as providing treatment abuse services 20 hours or less per week) must complete Items I, II, V, VI, VII, X, XI, XII, XIII (if applicable), and XIV.

Relocation

A substance abuse clinic or satellite site that is moving or expanding must complete Items I, V, VI, VII, IX (if applicable), XI, XII, XIV, and any other Items necessary to report a change in information.

Change of Ownership

A substance abuse clinic applying for a change of ownership must complete all sections of the four-page application and supply all required documentation. In addition, a Medi-Cal Disclosure Statement (form DHS 6207) must accompany the application.

Upon completion of the application, attach a cover letter describing your request. Include any additional information that would be helpful to the Department in processing your application. Be sure that the application is signed on the final page, supply all required documentation, and return the application to the Department of Alcohol and Drug Programs (ADP). It is important to note that substance abuse clinics cannot be reimbursed under the DMC program until the new clinic, service, funding, location, or ownership has been certified. The certification process usually includes an on-site review.

The following instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions are given to questions considered self-explanatory. These instructions apply to clinics and satellite sites.

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Item I. Indicate the name and address of the legal entity in control of the clinic. If a corporation, indicate the name as it appears on the Articles of Incorporation. If a partnership, the name as it appears on the partnership agreement. If a county, indicate the name as it appears on the county charter.

Include the four-digit Medi-Cal number if previously assigned, i.e., if a provider is applying for additional services or funding, to add a satellite site, or for relocation.

Insert the six-digit number under which the program reports participant information, i.e., California Alcohol and Drug Program Data System (CAADS) number.

Indicate to what mailing address mail, e.g., the compliance report, Certificate and Transmittal, Department notifications regarding the DMC program, should be sent.

Item II. Include the name of the clinic director (the individual responsible for the day-to-day operation of the clinic) and the executive director (the individual responsible for representing the legal entity in the operation of the clinic).

Item III. Identify the type of legal entity in control of the clinic and attach the requested documentation. For a corporation, attach a copy of the Articles (as filed with and endorsed or stamped by the Secretary of State). For a partnership, attach a copy of the partnership agreement.

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Item V. If the DMC program operates at the same location as a program providing another type of services, e.g., driving under the influence or certified alcohol and/or other drug program, and only the DMC certified program is relocating, indicate this information. Or if only a portion of the services provided at the DMC clinic are relocating, indicate this information. Or indicate the relocation of the entire program.

Item VI. Enter **all** services to be provided by the DMC clinic, including existing services and additional services being requested.

A narcotic treatment program license from ADP is required to provide narcotic treatment program services.

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Item IX. A residential alcoholism or drug abuse recovery or treatment facility license from ADP is required to provide adult perinatal residential substance abuse services. The facility must have a maximum treatment capacity of 16 beds or less. Beds occupied by children who stay in the facility with their mothers are not counted in the 16-bed limit.

If the site is licensed as a community care facility by the Department of Social Services (DSS), attach a written waiver from the DSS District Office to allow the use of a portion of the facility or grounds for nonlicensed service activities. Contact DSS District Office for the requirements and procedures.

Note – the Department of Health Services licenses primary care clinics. Refer to Health and Safety Code Section 1201 regarding the licensure requirements for these clinics.

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Item XI. Attach a copy of a current fire clearance for an inspection that has been conducted within the previous 12 months and that clearly identifies the clinic by name and address. A fire clearance is not required if the clinic is located entirely on public school grounds. A letter from the principal authorizing the provision of services and certifying that all locations where services are provided meet fire safety rules and regulations is sufficient.

Item XII. Local zoning approval is required for all clinics except: 1) those located entirely on public school grounds, and 2) those operated in a building that is owned or leased by a public entity. For a clinic located entirely on public school grounds, attach a letter from the principal authorizing the provision of services on public school grounds. For a clinic operated in a building that is owned or leased by a public entity, local zoning approval is not required. A letter stating that this is the case is sufficient.

Item XIII. An office-based opiate treatment program (OBOT) is required to be either 1) licensed by ADP, or 2) affiliated with a licensed narcotic treatment program or licensed OBOT. A medication unit is required to be affiliated with a licensed narcotic treatment program. Attach proof of affiliation.

Application for Drug Medi-Cal Program Participation for Substance Abuse Clinics

This form must be completed for each site desiring to participate in the Drug Medi-Cal program.
See the General and Specific Instructions for instructions on completing this application.

<table>
<tr><td rowspan="8">I.
Identifying Information for Substance Abuse Clinic</td><td>Legal Entity Name (for entity in control of clinic or satellite site)</td><td>Medi-Cal Provider Number, if assigned:</td></tr>
<tr><td>Program/Clinic Name</td><td>Do you have a six-digit number under which you report client information? No ☐ Yes ☐, write number below:</td></tr>
<tr><td>Street Address (where services will be provided)</td><td>Program Telephone Number:
( )</td></tr>
<tr><td>City, State, Zip Code</td><td rowspan="3">Type of location (clinic, doctor's office, residential facility, etc.)</td></tr>
<tr><td>Mailing Address</td></tr>
<tr><td>City, State, Zip Code</td></tr>
<tr><td>Federal Employer Identification Number (FEIN):</td></tr>
<tr><td>If clinic site is leased or rented, full name and address of owner</td><td>County of program operation</td></tr>
<tr><td rowspan="2">II.
Administration</td><td>Clinic Director:</td><td>Telephone Number:
( )</td></tr>
<tr><td>Executive Director:</td><td>Telephone Number:
( )</td></tr>
<tr><td>III.
Type of Agency or Entity in Control of Clinic</td><td colspan="2">Check one and complete or attach additional information for legal entity:
☐ Sole proprietorship
☐ Partnership (Attach copy of partnership agreement)
☐ Not for profit corporation (Attach copy of Articles of Incorporation)
☐ Other corporation (Attach copy of Articles of Incorporation)
☐ Government entity
☐ Other</td></tr>
</table>

IV. Funding Sources	Identify the sources of funds and income for operations (i.e. client fees, third party payers [insurance companies, employee health plans] county funds, state funds [include department and fund source, if known] other public funds, etc.)
V. Type of Application	Check all that apply ☐ Original Application ☐ Adding Satellite Site (20 hours or less of service per week) ☐ Additional Services or Funding ☐ Relocation, From: _____ Effective Date: _____ Is this a relocation of the entire program or only the Drug Medi-Cal component? Entire Program ☐ Medi-Cal component only ☐ ☐ Change of ownership, From: _____ ☐ Other, please specify: _____
VI. Service Modality(ies) and Funding	Identify the service modality(ies) and funding (regular or perinatal) requested for the site. If the site is currently certified, include current service modality(ies)and funding that the provider wishes to continue. Narcotic Treatment Program Regular ☐ Perinatal ☐ Day Care Rehabilitative Perinatal ☐ Perinatal Residential Perinatal ☐ Naltrexone Regular ☐ Outpatient Drug Free Regular ☐ Perinatal ☐
VII. Hours of Service Provision	☐ More than 20 hours per week (substance abuse clinic) ☐ 20 hours a week or less (satellite site)
VIII. Drug Protocol	☐ Attached is a drug protocol for each service modality being requested (narcotic treatment program, day care rehabilitative, perinatal residential, naltrexone, outpatient drug free)

IX. For Perinatal Residential Substance Abuse Applicants Only	Is the facility separately licensed by the Department of Alcohol and Drug Programs for **no more than** 16 treatment beds? Yes ☐ No ☐ Number of treatment beds: _____
	Are all food, shelter, and alcohol or drug recovery or treatment services provided at the licensed facility? If no, what services are provided on site, what services are provided offsite, who provides the services and at what address are the services provided? Yes ☐ No ☐
	Are any food, shelter, or alcohol or drug abuse recovery or treatment services provided at the facility for another licensed residential facility? If yes, list what services are provided and the name and address of the facility for which these services are provided. Yes ☐ No ☐
X. Staff	All programs must designate a medical director and a clinic director. Personnel files must match information on application. List the staff that will provide direct treatment services at this location. Include staff under contract. Attach a separate piece of paper if necessary. *Name* *Function* _____ _____ Medical Director _____ Clinic Director _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ ☐ For an office based opiate treatment program (OBOT) satellite site, a copy of the physician or pharmacy license is attached. ☐ Attached is a copy of the Medical Director's current license from the Medical Board of California.

XI. Fire Clearance	☐ Attached is a valid fire clearance from the local authority assuring that all fire safety requirements have been met and issued no more than 12 months prior to the date of this application. ☐ The site is located entirely on public school grounds. Attached is a letter from the school principal certifying that all locations where substance abuse services are provided meet fire safety rules and regulations.
XII. Local Zoning Approval	Check one of the following that applies to the site: ☐ Attached is documentation of local zoning approval for the site and services requested. ☐ The site is located entirely on public school grounds. Attached is a letter from the school principal authorizing the provision of services. ☐ The site is located entirely within a building that is owned or leased by a city, county, or state and is exempt from zoning approval requirements. ☐ The site is not required to obtain local zoning approval. Attached is a letter from the local agency responsible for issuing zoning approval stating that zoning approval is not required.
XIII. Narcotic Program Affiliation	For a medication unit or a satellite OBOT: ☐ Attached is proof of affiliation with a licensed Narcotic Treatment Program or affiliation with a licensed OBOT.
XIV. For Individual Signing the Application	If the applicant is a sole proprietorship, the application shall be signed by the sole proprietor; if a partnership, by each partner; or if a firm, association, corporation, or government entity, by the chief executive officer or individual legally responsible for representing the entity. ☐ Attached is a copy of the resolution or Board minutes authorizing the individual to sign. ☐ Attached is a copy of the individual's Social Security Card. _____ Date of Birth

I certify that the legal entity/provider applying to participate in the Drug Medi-Cal program is not barred from certification under Section 14043.36 of the Welfare and Institutions Code and that the information contained in this application and supporting documentation is true and correct.

Signature of authorized official Title Name (Typed or Printed) Date